UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ARANESP (darbepoetin alfa)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

Diagnosis_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Diagnosis of anemia associated with renal failure
- Diagnosis of anemia associated with chemotherapy
- Patient is not on dialysis
- No GI bleeding
- Hematocrit <33% supported by lab work done within the past 3 months (**FAX COPY OF LAB-WORK**)
- Hemoglobin <11% supported by lab work done within the past 3 months(**FAX COPY OF LAB-WORK**)
- Prescribing authority limited to hematologist, oncologist, nephrologist and infectious disease specialists or based upon a consult with one of these specialists.

INITIAL AUTHORIZATION:

6 Months

RE-AUTHORIZATION:

No GI bleeding, not on dialysis. Hematocrit <39% , Hemoglobin 11-13 supported by lab data done within the past 3 months**. (FAX COPY OF LAB-WORK)**